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**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**LESLIE ANN ROHMANN**<br>**9736 Shamrock Lane**<br>**Lakeside, CA 92040**<br><br>**Registered Nurse License No. 685713**<br><br>Respondent. | Case No. 2011-543<br><br>**A C C U S A T I O N** |

Complainant alleges:

**PARTIES**

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 7, 2006, the Board of Registered Nursing issued Registered Nurse License Number 685713 to Leslie Ann Rohmann (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2012, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

## STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner

dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 4060 of the Code states, in pertinent part, that no person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor.

**REGULATORY PROVISIONS**

10. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

**COSTS**

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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## DRUGS

12. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K) and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Demerol, a brand name for meperedine hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (c)(17), and is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

## FACTUAL ALLEGATIONS

**Division of Investigation Case No. 2008-08-1030**

15. Respondent was employed by Pacific Coast HealthCare (PCH), a nurse registry, from February 6, 2008 to June 1, 2008. While under the part-time, per diem employment of PCH, Respondent was assigned to work in the Emergency Department of Tri-City Medical Center (TCMC) in Oceanside, California, from March 8, 2008 through May 15, 2008. On or about May 22, 2008, the Board received a complaint from TCMC alleging that Respondent had been suspected of diverting controlled substances while she was assigned to TCMC. TCMC notified PCH of the pending investigation and requested a "Do Not Return" on Respondent's employment status with the hospital.

16. An investigation revealed that on May 15, 2008, there were discrepancies in various patients' hospital records, Medical Administration Records (MAR), and Pyxis[1] for whom

[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wastage must be disposed of in accordance with hospital rules and must be witnessed by another authorized user. Wastage must also be documented in the Pyxis machine.

Respondent administered medications, and that Respondent diverted medications prescribed for patients as follows:

17. MRN #01116601: At 14:31 hours, Respondent withdrew 2 mg of hydromorphone from Pyxis under this patient's name and wasted 2 mg at 1455 hours. Only 1 mg of hydromorphone had been ordered by the physician. Respondent did not note the administration of the hydromorphone on the patient's MAR.

18. MRN #01140417: At 16:50 hours, Respondent withdrew 3 mg of hydromorphone under this patient's name. Only 1 mg of hydromorphone was ordered by the physician. The administration of 1 mg hydromorphone was noted in the MAR, however, none was recorded wasted in Pyxis. Respondent did not account for 2 mg of hydromorphone.

19. MRN #01110620: At 19:47 hours, Respondent withdrew 4 mg of hydromorphone under this patient's name. Only 0.5 mg was ordered by the physician. Respondent wasted 3.5 mg at 21:13 hours.

20. MRN #01152959: At 20:29 hours, Respondent withdrew 1 mg of hydromorphone under this patient's name and noted 1 mg administered in the patient's MAR. This patient was in another section and not assigned to Respondent.

21. MRN #01152955: At 21:17 hours, Respondent withdrew 10 mg of hydromorphone even though there was a physician order for 4 mg of hydromorphone for this patient. Hydromorphone was available in Pyxis in 4 mg doses. At 22:40 hours, Respondent wasted 6 mg of hydromorphone.

**Division of Investigation Case No. 09-00508-RN**

22. Respondent was hired by Sharp Chula Vista Medical Center (SCVMC) as a fulltime registered nurse on August 21, 2008. On November 29, 2008, Respondent was missing from the Emergency Department for two hours and returned in a disoriented state. Respondent's behavior prompted a review of the medical records of the patients she was caring for. A review of the Pyxis reports covering a two-month period revealed that Respondent had been withdrawing multiple syringes of Dilaudid, Demerol, and Morphine in larger amounts than ordered, when

smaller amounts were available, and she failed to follow hospital policies and procedures for wasting narcotics. Respondent was allowed to resign in lieu of termination on December 9, 2008.

23. On December 29, 2008, the Board received a complaint from the SCVMC Manager alleging Respondent had allegedly engaged in the diversion of controlled substances while employed by SCVMC. As a result of the complaint, a DOI investigator was assigned to conduct a review of the allegations. The Manager provided a redacted copy of 28 Emergency Department charts and Pyxis Reports for patients assigned to Respondent during the period of October 2, 2008 to December 1, 2008. The documentation revealed numerous discrepancies and various wasting scenarios where Respondent withdrew larger amounts of narcotic medications than were ordered, and wasted the excess amounts as much as three hours later instead of returning the medications to Pyxis. Examples of the discrepancies are as follows:

24. MR #60667002 (October 2, 2008): The physician ordered 2 mg morphine for this patient and then cancelled the order at 01:17 hours. The physician ordered 1 mg Dilaudid at 01:28 hours and then cancelled that order. Respondent documented that she wasted 2 mg morphine at 01:34 hours. (The medication should have been returned to Pyxis.) Respondent documented in the MAR that she administered 1 mg Dilaudid at 01:49 hours. Respondent withdrew an additional dose of Dilaudid 1 mg at 02:14 and documented in the MAR that it was administered at 02:19 (thirty minutes after the previous dose and after the physician cancelled the order for Dilaudid).

25. MR #60666993 (October 2, 2008): For this patient, the physician ordered 1 mg Dilaudid for this patient at 02:23 hours. Respondent withdrew 2 mg Dilaudid at 02:23 and documented in the MAR that she administered 1 mg Dilaudid at 02:32 and wasted 1 mg Dilaudid at 02:36. (Dilaudid was available in 1 mg doses.)

26. MR #60668459 (October 5, 2008): For this patient, the physician ordered 1 mg Dilaudid at 20:39 hours. Respondent withdrew 4 mg Dilaudid at 20:45 and documented in the MAR that she administered 1 mg Dilaudid at 21:19. Respondent documented that she wasted 3 mg Dilaudid at 23:03, nearly two hours after she withdrew the narcotic from Pyxis. (Dilaudid was available in 1 mg doses.)

27. MR #60668514 (October 6, 2008): For this patient, Respondent withdrew 2 mg Dilaudid from Pyxis at 01:38 before 1 mg was ordered by Respondent at 01:59 hours ("Verbal order with read back to MD"). Respondent documented she wasted 1 mg Dilaudid at 01:53. Respondent withdrew another 1 mg dose of Dilaudid at 02:06 and documented in the patient's MAR that it was administered at 02:02, before it was removed from Pyxis.

28. MR #60673617 (October 16, 2008): For this patient, Respondent ordered 1 mg Dilaudid at 04:31 hours ("Verbal order with read back to MD"). Respondent withdrew 2 mg Dilaudid from Pyxis at 04:29 and documented in the MAR that 1 mg was administered at 04:32. Respondent documented she wasted 1 mg Dilaudid at 07:09, over 2.5 hours later. (Dilaudid was available in 1 mg doses.)

29. MR #60675581 (October 21, 2008): For this patient, 1 mg Dilaudid was ordered at 02:25 hours. Respondent withdrew 2 mg Dialudid at 02:26 and documented in the MAR that she administered 1 mg Dilaudid at 02:25. Respondent wasted 1 mg Dilaudid at 03:52, 1.5 hours later. (Dilaudid was available in 1 mg doses.)

30. MR #60678951 (October 28, 2008): For this patient, the physician ordered 1 mg Dilaudid at 04:25 and Respondent withdrew 2 mg Dilaudid at 04:25. Respondent documented that she administered 1 mg Dilaudid at 04:31. (Dilaudid was available in 1 mg doses.) There was no record of wastage and 1 mg Dilaudid was unaccounted for in the patient's MAR and Pyxis.

31. MR #60681101 (October 31, 2008): For this patient, 1 mg Dilaudid was ordered at 21:25 hours. Respondent withdrew 2 mg Dialudid at 21:25 and wasted 1 mg. Respondent documented in the MAR that she administered 1 mg Dilaudid at 21:25. (Dilaudid was available in 1 mg doses.) Respondent removed another 2 mg dose of Dilaudid for this patient at 21:36, and wasted 1 mg. The patient's MAR indicates another RN administered an additional 1 mg Dilaudid at 21:39.

32. MR #60680688 (October 31, 2008): For this patient, the physician ordered Dilaudid at 07:06. Respondent withdrew 2 mg Dilaudid at 07:11 and documented in the MAR with a note stating "Patient not to receive IV pain medication at the time, patient to receive oral medication

instead." Respondent documented that she wasted 2 mg Dilaudid at 07:19 instead of returning it to Pyxis.

33. MR #60682958 (November 4, 2008): For this patient, Respondent ordered 1 mg Dilaudid at 01:49 hours ("Verbal order with read back to MD"). Respondent withdrew 2 mg Dilaudid at 01:54. Respondent documented in the MAR that 1 mg Dilaudid was administered at 01:48; 1 mg Dilaudid was wasted at 02:00. (Dilaudid was available in 1 mg doses.)

34. MR #60682343 (November 4, 2008): For this patient, Respondent withdrew 10 mg of morphine at 00:29. There was no physician order for morphine for this patient. The Pyxis report shows 10 mg morphine was wasted at 00:43 rather than returned to Pyxis. The MAR shows that Demerol 12.5 mg was ordered for the patient at 00:38 and allegedly administered by RN Vargas at 00:49, however, Vargas had clocked out at 19:30 the previous evening.

35. MR #60682363 (November 4, 2008): For this patient, the physician ordered 2 mg Dilaudid at 06:40. Respondent withdrew 4 mg Dilaudid from Pyxis at 07:20 and wasted 2 mg. Respondent recorded that she administered 2 mg Dilaudid at 06:54 in the MAR. (Dilaudid was available in 2 mg doses.)

36. MR #60684654 (November 7, 2008): For this patient, the physician ordered 0.5 mg Dilaudid at 03:05. Respondent withdrew 1 mg Dilaudid from Pyxis at 03:11 and documented in the MAR that she administered 0.5 mg Dilaudid at 03:08. Wastage of the remaining 0.5 mg Dilaudid was not recorded and is unaccounted for.

37. MR #60684817 (November 8, 2008): For this patient, the physician ordered 2 mg morphine at 21:47. Respondent withdrew 10 mg morphine, 8 mg more than the ordered amount, from Pyxis at 22:13 and documented in the MAR that she administered 2 mg morphine at 22:15. Respondent documented that she wasted 8 mg morphine at 23:38, nearly 1.5 hours later.

38. MR #60685013 (November 10, 2008): Respondent withdrew 2 mg of Dilaudid for this patient who was not assigned to her. There was no documentation charted in the patient's MAR that Respondent administered the Dilaudid and no wastage recorded in Pyxis. Two mg of Dilaudid was unaccounted for.

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39. MR #60688360 (November 16, 2008): For this patient, Respondent withdrew 2 mg Dilaudid at 20:05, then wasted 2 mg Dilaudid at 21:57, nearly two hours later, rather than return it to Pyxis. There was no order for Dilaudid in the patient's record.

40. MR #60688388 (November 17, 2008): For this patient, the physician ordered 1 mg Dilaudid at 02:12. Respondent withdrew 2 mg Dilaudid and administered 1 mg at 02:13. Respondent documented that she wasted 1 mg Dilaudid at 04:06, two hours later. Dilaudid was available in 1 mg doses.

41. MR #60688951 (November 17, 2008): Respondent withdrew 10 mg morphine at 19:53 for this patient who did not belong to her. Respondent wasted 10 mg morphine at 21:25, 1.5 hours later, instead of returning it to Pyxis.

42. MR #6068750 (November 17, 2008): For this patient, the physician order 4 mg morphine at 19:26. Respondent withdrew 10 mg morphine at 19:26 for this patient who did not belong to her. The patient's primary nurse charted that he administered 4 mg morphine at 19:27. Respondent documented the wastage of 6 mg morphine at 20:23, an hour later.

43. MR #60689546 (November 18, 2008): For this patient, the physician ordered 2 mg morphine at 19:52. Respondent withdrew 10 mg morphine at 19:48, 8 mg more than ordered, and documented in the MAR that she administered 2 mg morphine at 19:52. Wastage of 8 mg morphine was recorded at 20:34, 44 minutes later.

44. MR #60692913 (November 26, 2008): For this patient, the physician ordered 0.5 mg Dilaudid at 03:10. Respondent withdrew 1 mg Dilaudid at 03:17 and documented in the MAR that she administered 0.5 mg Dilaudid at 03:24. Respondent documented that she wasted 0.5 mg Dilaudid at 07:01, 3.5 hours later.

45. MR #60693784 (November 29, 2008): For this patient, the physician ordered 2 mg Valium (diazepam). An extern withdrew 10 mg of diazepam at 02:16. Respondent documented that she administered 2 mg Valium at 02:19 and wasted 5 mg Valium at 04:14, two hours later. This left 3 mg Valium unaccounted for, however, the primary nurse (who was not Respondent) charted that she administered 3 mg of Valium at 04:13.

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46. MR #60694109 (November 30, 2008): For this patient, Respondent withdrew 2 mg hydromorphone at 22:21 then documented the wastage of 2 mg hydromorphone at 00:59. There was no order for this narcotic in the patient's record and it should have been returned to Pyxis rather than wasted 2.5 hours later.

47. MR #60693958 (November 30, 2008): For this patient, the physician ordered 1 mg Dilaudid at 04:00. Respondent withdrew 2 mg Dilaudid at 04:01 and documented in the MAR that she administered 1 mg Dilaudid at 04:01. Respondent documented she wasted 1 mg Dilaudid at 06:28, 2.5 hours later. Dilaudid was available in 1 mg doses.

48. MR #60693967 (November 30, 2008): For this patient, the physician ordered 1 mg Dilaudid at 01:49. Respondent withdrew 2 mg Dilaudid at 01:53 and documented in the MAR that she administered 1 mg Dialudid at 01:53. Respondent documented she wasted 1 mg Dilaudid at 03:44, nearly 2 hours later. Dilaudid was available in 1 mg doses.

49. MR #60694163 (December 1, 2008): For this patient, the physician ordered 1 mg Dilaudid at 04:35. Respondent withdrew 2 mg Dilaudid at 04:46 and documented in the MAR that she administered 1 mg Dilaudid at 04:51. Respondent documented she wasted 1 mg Dilaudid at 07:40, nearly 3 hours later. Dilaudid was available in 1 mg doses.

50. MR #606941148 (December 1, 2008): For this patient, the physician ordered 0.5 mg Dilaudid at 01:44. Respondent withdrew 2 mg Dilaudid at 01:41 and documented in the MAR that the patient refused the medication at 01:43. Respondent recorded that she wasted 2 mg Dilaudid at 01:55 rather than retun it to Pyxis. Dilaudid was available in 1 mg doses.

**DOI Contact With Respondent**

51. Both of the above investigations were assigned to the same DOI investigator. The investigator made multiple attempts in 2009 to contact Respondent at various addresses, phone numbers, and e-mail accounts. Finally, in February 2010, Respondent consented to authorize the release of her personnel records from her employers and submit to an interview. During the February 18, 2010 interview with the investigator, Respondent stated that it was her practice to draw up medications to cover her patients based on their level of pain and hold onto the

medications until they were needed. She typically did not waste the medications until the patients were discharged or admitted to another floor. Respondent claimed that she had never been counseled by her employers about her irregular practice of drawing up medications for a patient and then wasting it at a later time. Respondent denied that she used drugs, diverted drugs, or stole drugs from her employers. On or about February 18, 2010, Respondent submitted to a forensic drug test which subsequently tested positive for hydrocodone, hydromorphone, oxycodone, and oxymorphone. Respondent stated in the pre-test questionnaire that she was taking Oxycodone-APAP 5-325 prescribed by a doctor for migraine headaches.

52. The DOI Investigator obtained a copy of the Controlled Substance Utilization & Evaluation System (CURES) Patient Prescription History for Respondent for a five-year period from February 2, 2005, through February 26, 2010. The seven-page CURES report lists numerous prescriptions for APAP-Hydrocodone from numerous physicians in different cities for the period of February 2, 2005 to September 5, 2007. Respondent had been prescribed Suboxone and Subutex for the period of September 18, 2007 to June 20, 2008. The prescriptions were filled at various Kaiser Permanente pharmacies. (Suboxone is used to treat opioid addiction.) Additionally, Respondent obtained six prescriptions for APAP-Hydrocodone bitartate from five different physicians in different cities from the period of July 10, 2009 to January 9, 2010.

53. On April 30, 2010, the investigator obtained a copy of Respondent's treatment records from Kaiser Permanente, which did not specifically include the records for any substance abuse treatment. However, the records did indicate that Respondent admitted to a past history of intravenous drug use and that on October 8, 2007, Respondent stated that she had been clean from heroin for 9 weeks. In her interview with the DOI investigator, Respondent continued to deny that she had a drug problem and stated that she did not need to enter the Board's diversion program because she does not use or abuse drugs.

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**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

54. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was grossly negligent, as defined by California Code of Regulations, title 16, section 1442, in that during the period from March 8, 2008 to May 15, 2008, while employed by TCMC (as detailed in paragraphs 15-21, above), and during the period of October 2, 2009 to December 1, 2009, while employed by SCVMC (as detailed in paragraphs 22-50, above), Respondent repeatedly removed controlled substances from Pyxis and failed to properly document her handling of the medications in the hospital's MAR's, medical records, or Pyxis. Respondent repeatedly failed to properly document wastage, repeatedly removed more medication than was ordered or necessary, and routinely kept controlled substances in her personal possession without properly accounting for said medications. Respondent further withdrew medications for patients who were not assigned to her or who were in a different section of the hospital, and withdrew medications outside the prescribed timeframe to do so. Respondent's actions demonstrated an extreme departure from the standard of care in that she repeatedly failed to perform her nursing duties as they would have ordinarily been exercised by a competent registered nurse.

**SECOND CAUSE FOR DISCIPLINE**

**(Illegal Possession of Controlled Substances)**

55. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as detailed in paragraphs 15-51, above, Respondent obtained and possessed in violation of law controlled substances taken from her employers.

**THIRD CAUSE FOR DISCIPLINE**

**(Illegal Use of Controlled Substances)**

56. Respondent is subject to disciplinary action under section 2762, subdivision (b) of the Code for unprofessional conduct in that on occasions as described in paragraph 22, above, Respondent used or was under the influence of controlled substances to the extent that it impaired

her ability to conduct with safety to her patients the practice of nursing. She was observed by her employers and coworkers to be exhibiting behavior consistent with the use of controlled substances. Further, a forensic drug screen revealed Respondent had consumed controlled substances not prescribed to her according to the Controlled Substance Utilization & Evaluation System (CURES) Patient Prescription History for Respondent, as detailed in paragraph 52, above.

**FOURTH CAUSE FOR DISCIPLINE**

**(Inaccurate Documentation in Hospital Records)**

57. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 15-51, above, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis records pertaining to controlled substances prescribed to patients under her care.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 685713, issued to Leslie Ann Rohmann;

2. Ordering Leslie Ann Rohmann to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/16/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

SD2010701954